TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GRAPEVINE SURGICARE PARTNERS

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-3813-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
AUGUST 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Comp Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $2,763.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The total amount due is $10,370.04. Texas Mutual paid $9,840.31. An additional payment of $529.73 is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2016	Ambulatory Surgical Care CPT Code 63650	$1,116.97	$831.05
	Ambulatory Surgical Care CPT Code 63650	$1,645.72	
TOTAL		$2,763.69	$831.05

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 725-Approved non-network provider for Texas Star Network Claimant per rule 1305.153(c).
   - 763-Paid per ASC FG at 235%: Implants not applicable or separate reimbursement (w/signed cert) not requested: Rule 134.402(G).
   - CAC-18-Exact duplicate claim/service.
   - 736-Duplicate appeal. Network contract applied by Texas Star Network.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 724-No additional payment after a reconsideration of services.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for code 63650?

Findings

The requestor is seeking reimbursement for ambulatory surgical care services rendered to the claimant on April 4, 2016.

The requestor wrote "At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Comp Fee Schedule and Guidelines for Ambulatory Surgical Centers."

The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

According to the explanation of benefits, the respondent paid $9,840.31 for code 63650 based upon the fee schedule.

28 Texas Administrative Code §134.402(d) states, " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

28 Texas Administrative Code §134.402(f)(2) states "Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent; or (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the ASC service portion multiplied by 235 percent."

According to Addendum AA, CPT code 63650 is a device intensive procedure.

A. To determine the MAR for code 63650 is a five-step process:

1. **Step 1-Gather factors**:
   - According to Addendum B found on CMS website, the hospital outpatient prospective payment amount for code 63650 is $5,244.37.
   - The device dependent APC offset percentage found in Table 66 for National Hospital OPPS for code 63650for CY 2016 is 56.19%.
   - According to Addendum AA found on CMS website, CPT code 63650 has a Medicare ASC reimbursement of $3,993.90.
   - The Core Based Statistical Area (CBSA-City Wage Index) located on the White House/OMB website or CMS website for Grapevine, Texas is 0.9847.

2. **Step 2- To determine the device portion, you multiply the hospital outpatient prospective payment amount times the device dependent APC offset percentage**:
   $5,244.37 multiplied by 56.19% = $2,946.81.
3. **Step 3 - Find the geographically adjusted Medicare ASC reimbursement for code 63650. This step requires calculations**:
   - The Medicare fully implemented ASC reimbursement rate of $3,993.90 is divided by 2 = $1,996.95.
   - This number multiplied by the City Wage Index for Grapevine, TX $1,996.95 X 0.9847 = $1,966.40.
   - The sum of these two is the geographically adjusted Medicare ASC reimbursement $1,996.95 + $1,966.40= $3,963.35.
4. **Step 4- To determine the service portion:**
   - Subtract the device portion from the geographically adjusted Medicare ASC reimbursement $3,963.35 minus $2,946.81 = $1,016.54.
   - Multiply the service portion by the DWC payment adjustment factor of 235% $1,016.54 multiplied by 235% = $2,388.87
5. **Step 5-Add the service and device portion together to determine MAR**.
   $2,388.87 + $2,946.81 = $5,335.68.

The requestor billed for two units. Per Addendum AA, code 63650 is not subject to multiple procedure discounting; therefore, $5,335.68 X2 = $10,671.36.

The respondent paid $9,840.31. The difference between amount paid and due is $831.05.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $831.05.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $831.05 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	09/29/2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.